

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

01864

1892

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East (Rural)				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Jennie L. Armour				4. DATE OF DEATH Month Day Year February 4 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 15, 1881	9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME William T. Montgomery				14. MOTHER'S MAIDEN NAME Catherine V Cloud			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Mrs. Herbert G. Cooper, Charlestown, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE 441X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertension Malignant (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Sept. 10, 1957, to Jan. 30, 1957, that I last saw the deceased alive on 1-30-57, 19, and that death occurred at 7 A. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE R. C. Dodson				ADDRESS (Street, city or town, state) Rising Sun, Md.		DATE SIGNED 2-5-58	
PHYSICIAN'S NAME (Type) R. C. Dodson, M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 7, 1958		22c. NAME OF CEMETERY OR CREMATORY Ebenezer Cemetery		22d. LOCATION (City, town, or county) (State) Rising Sun (Rural) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant				ADDRESS North East, Maryland.		24a. REC'D BY REGISTRAR DATE FEB 10 '58	
				24b. REGISTRAR'S SIGNATURE R. C. Dodson			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be kept with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DEATH OF <b>JOHN V. BROWN</b> DATE OF DEATH <b>1958 10 10</b> PLACE OF DEATH <b>HOME</b>		DEATH OF <b>JOHN V. BROWN</b> DATE OF DEATH <b>1958 10 10</b> PLACE OF DEATH <b>HOME</b>	
SEX <b>MALE</b> AGE <b>68</b> BIRTH DATE <b>1912 08 15</b> BIRTH PLACE <b>NEW YORK</b>		SEX <b>MALE</b> AGE <b>68</b> BIRTH DATE <b>1912 08 15</b> BIRTH PLACE <b>NEW YORK</b>	
OCCUPATION <b>RETIRED</b> MARITAL STATUS <b>MARRIED</b> SPOUSE'S NAME <b>MARY V. BROWN</b>		OCCUPATION <b>RETIRED</b> MARITAL STATUS <b>MARRIED</b> SPOUSE'S NAME <b>MARY V. BROWN</b>	
CAUSE OF DEATH <b>HEART DISEASE</b> ICD CODE <b>410</b>		CAUSE OF DEATH <b>HEART DISEASE</b> ICD CODE <b>410</b>	
PLACE OF DEATH <b>HOME</b> COUNTY <b>BALTIMORE</b>		PLACE OF DEATH <b>HOME</b> COUNTY <b>BALTIMORE</b>	
SIGNATURE OF DECEASED <b>JOHN V. BROWN</b> DATE <b>1958 10 10</b>		SIGNATURE OF DECEASED <b>JOHN V. BROWN</b> DATE <b>1958 10 10</b>	
SIGNATURE OF WITNESS <b>MARY V. BROWN</b> DATE <b>1958 10 10</b>		SIGNATURE OF WITNESS <b>MARY V. BROWN</b> DATE <b>1958 10 10</b>	
SIGNATURE OF PHYSICIAN <b>DR. J. H. BROWN</b> DATE <b>1958 10 10</b>		SIGNATURE OF PHYSICIAN <b>DR. J. H. BROWN</b> DATE <b>1958 10 10</b>	
SIGNATURE OF CORONER <b>JOHN V. BROWN</b> DATE <b>1958 10 10</b>		SIGNATURE OF CORONER <b>JOHN V. BROWN</b> DATE <b>1958 10 10</b>	

BUREAU V. S.

1958 10 10

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01865

1872

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Cecil Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN lb 12 hours		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East. R.D.3.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Walter Middle H. Last Boulden				4. DATE OF DEATH Month 2 Day 7 Year 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH April 7, 1881		9. AGE (In years last birthday) 76 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Lab.		10b. KIND OF BUSINESS OR INDUSTRY Retired		11. BIRTHPLACE (State or foreign country) North East, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jess Boulden				14. MOTHER'S MAIDEN NAME Elizabeth Thompson			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 219-05-6422		17. INFORMANT Ruth Spootswood, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Insufficiency and Bronchial Congestion 422.2 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 2-7-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-10-1958		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) North East, Cecil Co., Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Givens				ADDRESS North East, Md		24a. REC'D BY REGISTRAR FEB 11 1958 DATE	
				24b. REGISTRAR'S SIGNATURE W. J. Smith			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, the certificate should be written in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 11 1958

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01866

1893

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora, Rural</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Colora, Rural</u>			
c. LENGTH OF STAY IN 1b <u>All life</u>				d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>1</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Clayton</u> Middle <u>Mitchell</u> Last <u>Brown, Jr.</u>				4. DATE OF DEATH Month <u>2</u> Day <u>2</u> Year <u>19 58</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-16-1933</u>	9. AGE (In years last birthday) <u>24</u> yrs.	IF UNDER 1 YEAR Months <u>24</u> Days <u>2</u> Hours <u>19</u> Min.	IF UNDER 24 HRS. Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Auto. Mechanic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unemployed</u>		11. BIRTHPLACE (State or foreign country) <u>Conowingo, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Clayton Mitchell Brown, Sr.</u>				14. MOTHER'S MAIDEN NAME <u>Ailenn Blanche Curry</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>213-30-8001</u>		17. INFORMANT <u>Clayton, M. Brown, Conowingo, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Valvular disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Rheumatic Fever</u> (c) <u>gave rise to immediate cause (a), stating the underlying cause lost.</u> DUE TO							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>414X</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> o. m. <u>19</u> p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R.C. Dodson</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>R.C. Dodson</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>2-3-58</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>Feb 5/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Baptist Cem</u>		22d. LOCATION (City, town, or county) <u>Conowingo Md.</u>		(State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>L. Carl Tyson, Rising Sun, Md.</u>				24a. REC'D BY REGISTRAR <u>Feb 5 '58</u>		24b. REGISTRAR'S SIGNATURE <u>Dr. Smith</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

01868

1873

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b All life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last William Cooling				4. DATE OF DEATH Month Day Year 2 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2 - 27 - 1905	9. AGE (In years last birthday) 52 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Garage		10b. KIND OF BUSINESS OR INDUSTRY Auto Garage		11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Zachery Cooling				14. MOTHER'S MAIDEN NAME Emma Lowery			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 2nd World War 218-32-0455		17. INFORMANT Marie S. Cooling Chesapeake City, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R.C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/23/58		22c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		22d. LOCATION (City, town, or county) (State) Bethel Md.	
23. FUNERAL DIRECTOR'S SIGNATURE H. Walter duBois Jr.				ADDRESS Elkton Md.		24a. REC'D BY REGISTRAR FEB 25 58	
				24b. REGISTRAR'S SIGNATURE			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Form with multiple sections for medical examination, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten information.

BUREAU V. 3

FEB 25 1938

RECEIVED

Handwritten signatures and notes at the bottom of the form, including a signature that appears to be "J. Edgar Hoover".



Item 20 Film 226 5-0-58 ans

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
 1874

Reg. Dist. No. 01869

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D. 1	
c. LENGTH OF STAY IN lb 2 HRS		d. STREET ADDRESS 1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Deborah Lynnette Cox		4. DATE OF DEATH Month 2 Day 24 Year 19 58	
5. SEX Female	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 7, 1958
9. AGE (In years last birthday) 1 mo. 17 yrs.		IF UNDER 1 YEAR Months 1 Days 17	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) Havre de Grace, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Jack David Cox		14. MOTHER'S MAIDEN NAME Margarettee Fisher	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Jack D. Cox, North East, Md. R.D. #1		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Strangulation DUE TO 921.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Vomiting milk DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Vomiting milk with face down	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 2-24-58 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home		20f. (City or town) North East (County) Cecil (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R. D. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R. D. Dodson, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/58	
22c. NAME OF CEMETERY OR CREMATORY Delmar Manor Memorial Park		22d. LOCATION (City, town, or county) Md. Ellettsville Ind.	
23. FUNERAL DIRECTOR'S SIGNATURE		24a. REC'D BY REGISTRAR	
ADDRESS		24b. REGISTRAR'S SIGNATURE	
Pepper, General Home Ave. 473 E. Ellettsville, Md.		DATE FEB 26 '58	

2071222XV4

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 26 1953  
BUREAU V. S.

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1875

## CERTIFICATE OF DEATH

Reg. Dist. No. 01870

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE North Carolina b. COUNTY Forsyth	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elktion		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Winston Salem	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		d. STREET ADDRESS 402 Acadia St.	
3. NAME OF DECEASED (Type or print) First James Middle Crews Last Crews		4. DATE OF DEATH Month 2 Day 9 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Feb. 17, 1916
9. AGE (In years last birthday) 41 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Contractor		10b. KIND OF BUSINESS OR INDUSTRY Concrete Const.	
11. BIRTHPLACE (State or foreign country) Stokes Co. N.C.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME W.S. Crews		14. MOTHER'S MAIDEN NAME Jennie Campbell	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 243-10-2999	
17. INFORMANT Mrs. Evelyn Crews		Address Winston Salem, N.C.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Recurrent Coronary Occlusion & Infarct 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Aortic aneurysm 3 wks duration		INTERVAL BETWEEN ONSET AND DEATH 6 days Unknown	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 29 Jan, 1958, to 9 Feb, 1958, that I last saw the deceased alive on 8 Feb, 1958, and that death occurred at 5:30 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE George J. Kreis, Jr.		ADDRESS (Street, city or town, state) 2018 Main St Winston Salem	
PHYSICIAN'S NAME (Type) George J. Kreis, Jr.		DATE SIGNED 2/10/58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/11/58	
22c. NAME OF CEMETERY OR CREMATORY Hawpond Church of Christ		22d. LOCATION (City, town, or county) (State) Germanton, N. C.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Donald W. Lee Elkton, Md.	
24a. REC'D BY REGISTRAR FEB 14 '58		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

1. NAME OF DECEASED <i>John Doe</i>		2. SEX <i>Male</i>	
3. AGE <i>45</i>		4. RACE <i>White</i>	
5. DATE OF DEATH <i>Feb 14 1922</i>		6. PLACE OF DEATH <i>Home</i>	
7. CAUSE OF DEATH <i>Heart Disease</i>		8. DISEASE OR INJURY <i>Myocardial Infarction</i>	
9. SIGNATURE OF PHYSICIAN <i>John Doe</i>		10. SIGNATURE OF REGISTRAR <i>John Doe</i>	
11. SIGNATURE OF WITNESS <i>John Doe</i>		12. SIGNATURE OF WITNESS <i>John Doe</i>	
13. SIGNATURE OF WITNESS <i>John Doe</i>		14. SIGNATURE OF WITNESS <i>John Doe</i>	
15. SIGNATURE OF WITNESS <i>John Doe</i>		16. SIGNATURE OF WITNESS <i>John Doe</i>	
17. SIGNATURE OF WITNESS <i>John Doe</i>		18. SIGNATURE OF WITNESS <i>John Doe</i>	
19. SIGNATURE OF WITNESS <i>John Doe</i>		20. SIGNATURE OF WITNESS <i>John Doe</i>	
21. SIGNATURE OF WITNESS <i>John Doe</i>		22. SIGNATURE OF WITNESS <i>John Doe</i>	
23. SIGNATURE OF WITNESS <i>John Doe</i>		24. SIGNATURE OF WITNESS <i>John Doe</i>	
25. SIGNATURE OF WITNESS <i>John Doe</i>		26. SIGNATURE OF WITNESS <i>John Doe</i>	
27. SIGNATURE OF WITNESS <i>John Doe</i>		28. SIGNATURE OF WITNESS <i>John Doe</i>	
29. SIGNATURE OF WITNESS <i>John Doe</i>		30. SIGNATURE OF WITNESS <i>John Doe</i>	
31. SIGNATURE OF WITNESS <i>John Doe</i>		32. SIGNATURE OF WITNESS <i>John Doe</i>	
33. SIGNATURE OF WITNESS <i>John Doe</i>		34. SIGNATURE OF WITNESS <i>John Doe</i>	
35. SIGNATURE OF WITNESS <i>John Doe</i>		36. SIGNATURE OF WITNESS <i>John Doe</i>	
37. SIGNATURE OF WITNESS <i>John Doe</i>		38. SIGNATURE OF WITNESS <i>John Doe</i>	
39. SIGNATURE OF WITNESS <i>John Doe</i>		40. SIGNATURE OF WITNESS <i>John Doe</i>	
41. SIGNATURE OF WITNESS <i>John Doe</i>		42. SIGNATURE OF WITNESS <i>John Doe</i>	
43. SIGNATURE OF WITNESS <i>John Doe</i>		44. SIGNATURE OF WITNESS <i>John Doe</i>	
45. SIGNATURE OF WITNESS <i>John Doe</i>		46. SIGNATURE OF WITNESS <i>John Doe</i>	
47. SIGNATURE OF WITNESS <i>John Doe</i>		48. SIGNATURE OF WITNESS <i>John Doe</i>	
49. SIGNATURE OF WITNESS <i>John Doe</i>		50. SIGNATURE OF WITNESS <i>John Doe</i>	
51. SIGNATURE OF WITNESS <i>John Doe</i>		52. SIGNATURE OF WITNESS <i>John Doe</i>	
53. SIGNATURE OF WITNESS <i>John Doe</i>		54. SIGNATURE OF WITNESS <i>John Doe</i>	
55. SIGNATURE OF WITNESS <i>John Doe</i>		56. SIGNATURE OF WITNESS <i>John Doe</i>	
57. SIGNATURE OF WITNESS <i>John Doe</i>		58. SIGNATURE OF WITNESS <i>John Doe</i>	
59. SIGNATURE OF WITNESS <i>John Doe</i>		60. SIGNATURE OF WITNESS <i>John Doe</i>	
61. SIGNATURE OF WITNESS <i>John Doe</i>		62. SIGNATURE OF WITNESS <i>John Doe</i>	
63. SIGNATURE OF WITNESS <i>John Doe</i>		64. SIGNATURE OF WITNESS <i>John Doe</i>	
65. SIGNATURE OF WITNESS <i>John Doe</i>		66. SIGNATURE OF WITNESS <i>John Doe</i>	
67. SIGNATURE OF WITNESS <i>John Doe</i>		68. SIGNATURE OF WITNESS <i>John Doe</i>	
69. SIGNATURE OF WITNESS <i>John Doe</i>		70. SIGNATURE OF WITNESS <i>John Doe</i>	
71. SIGNATURE OF WITNESS <i>John Doe</i>		72. SIGNATURE OF WITNESS <i>John Doe</i>	
73. SIGNATURE OF WITNESS <i>John Doe</i>		74. SIGNATURE OF WITNESS <i>John Doe</i>	
75. SIGNATURE OF WITNESS <i>John Doe</i>		76. SIGNATURE OF WITNESS <i>John Doe</i>	
77. SIGNATURE OF WITNESS <i>John Doe</i>		78. SIGNATURE OF WITNESS <i>John Doe</i>	
79. SIGNATURE OF WITNESS <i>John Doe</i>		80. SIGNATURE OF WITNESS <i>John Doe</i>	
81. SIGNATURE OF WITNESS <i>John Doe</i>		82. SIGNATURE OF WITNESS <i>John Doe</i>	
83. SIGNATURE OF WITNESS <i>John Doe</i>		84. SIGNATURE OF WITNESS <i>John Doe</i>	
85. SIGNATURE OF WITNESS <i>John Doe</i>		86. SIGNATURE OF WITNESS <i>John Doe</i>	
87. SIGNATURE OF WITNESS <i>John Doe</i>		88. SIGNATURE OF WITNESS <i>John Doe</i>	
89. SIGNATURE OF WITNESS <i>John Doe</i>		90. SIGNATURE OF WITNESS <i>John Doe</i>	
91. SIGNATURE OF WITNESS <i>John Doe</i>		92. SIGNATURE OF WITNESS <i>John Doe</i>	
93. SIGNATURE OF WITNESS <i>John Doe</i>		94. SIGNATURE OF WITNESS <i>John Doe</i>	
95. SIGNATURE OF WITNESS <i>John Doe</i>		96. SIGNATURE OF WITNESS <i>John Doe</i>	
97. SIGNATURE OF WITNESS <i>John Doe</i>		98. SIGNATURE OF WITNESS <i>John Doe</i>	
99. SIGNATURE OF WITNESS <i>John Doe</i>		100. SIGNATURE OF WITNESS <i>John Doe</i>	

RECEIVED  
FEB 14 1922  
BUREAU V. 3

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1876

## CERTIFICATE OF DEATH

Reg. Dist. No. 01871

1. PLACE OF DEATH o. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Delaware b. COUNTY New Castle			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wilmington 46 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS			
3. NAME OF DECEASED First Middle Last Charles William Cullen				4. DATE OF DEATH February 8 19 58			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH January 20, 1888		9. AGE (In years lost birthday) 70 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Stereotype Operator				10b. KIND OF BUSINESS OR INDUSTRY Newspaper		11. BIRTHPLACE (State or foreign country) Delaware	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Elisha Beverly Cullen				14. MOTHER'S MAIDEN NAME Amelia Ellen Wheatley			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. W.W. 1 164-03-4708		17. INFORMANT Address Virginia Mrs. Mabel Hartman Charlottesville,			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 421-1 Calcific Aortic Stenosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Uremia. (b) (c)							INTERVAL BETWEEN ONSET AND DEATH unk.
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1, 1958, to 2-8, 1958, that I last saw the deceased alive on 2-8, 1958, and that death occurred at 12 M, from the causes and on the date stated above.							
ACTUAL SIGNATURE William Eppes M.D.				ADDRESS (Street, city or town, state) 325 E main Street Newark, Del.			
PHYSICIAN'S NAME (Type)				DATE SIGNED			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 10, 1958		22c. NAME OF CEMETERY OR CREMATORY The Union Cemetery		22d. LOCATION (City, town, or county) (State) Georgetown, Delaware	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS Elton, Md.		24a. REC'D BY REGISTRAR DATE FEB 13 58	
				24b. REGISTRAR'S SIGNATURE			

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



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100

BUREAU V. S.

FEB 13 1959

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1894

## CERTIFICATE OF DEATH

Reg. Dist. No.

01872

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Worcester</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN lb <b>1yr.5mo.15days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>Snow Hill</b>			
3. NAME OF DECEASED (Type or print) First <b>EDWARD</b> Middle <b>H.</b> Last <b>DAVIS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>26</b> Year <b>19 58</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>3-23-92</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months <b>65</b>	IF UNDER 24 HRS. Days <b>26</b> Hours <b>19</b> Min. <b>58</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Fisherman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Oyster</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Joshua H. Davis</b>				14. MOTHER'S MAIDEN NAME <b>Sally Merritt</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 231-42-7963</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO <b>420.0</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Emphysema of the lung</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>  <b>unknown</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>VA</b> 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>September 11, 1956</b> , to <b>February 26, 1958</b> , and that death occurred at <b>3:00 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		M.D. <b>V.A. Hospital, Perry Point, Md.</b>		DATE SIGNED <b>2-26-58</b>			
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/2/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Porterville M.E. Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Porterville Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Dennis &amp; Watson, Pocomoke City, Md.</b>				24a. REC'D BY REGISTRAR <b>Henry H. Watson</b>		24b. REGISTRAR'S SIGNATURE <b>Alb. Smith</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STANDARD BOND

CERTIFICATE OF DEATH

BUREAU V. 3

MAR 3 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1877

01873

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <b>N.Y.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		d. STREET ADDRESS <b>983 Post Ave</b>	
3. NAME OF DECEASED (Type or print) <b>Reinhold DellRoss</b>		4. DATE OF DEATH Month <b>2-8-58</b> Day Year <b>19</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>M</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-25-1908</b>
9. AGE (In years last birthday) <b>49</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stone Mason</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Contractor</b>	
11. BIRTHPLACE (State or foreign country) <b>Austria</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Henry DellRoss</b>		14. MOTHER'S MAIDEN NAME <b>Rose Schiller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Mary DellRoss</b>		Address <b>983 Post Ave Staten Island N.Y.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured Skull</b> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Station Wagon Turned over on him</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:35 p.m. 2 8 58</b>	20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40 Elkton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>2-8-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>2-8-58</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Staten Island, N.Y., N.Y.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ralph E. Hicks, Elkton, Maryland</b>		24a. REC'D BY REGISTRAR <b>DATE FEB 13 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>Alfred</b>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED  
FEB 13 1938  
BUREAU V. 3

RECEIVED

FEB 13 1938

BUREAU V. 3

Station wagon turned over on him

Tracked and killed

no Mrs. Mary Bellhouse 983 Post Ave Staten Island N.Y.

Henry Bellhouse

Joe Schiller

Staten Island

Director

Assistant

N.Y.C.

W

8-2-38

12

Reinhold

Illness

2-2-38

Union Hospital

983 Post Ave

Union

N.Y.C.

Staten Island 2

Cell

N.Y.C.

See page 10

1895

## CERTIFICATE OF DEATH

Reg. Dist. No.

01874

1. PLACE OF DEATH a. COUNTY <i>Cecil</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Cecil</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Carrowing, Md.</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural-Carrowing</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last <i>Edna Mae Devonshire</i>		4. DATE OF DEATH Month Day Year <i>2-9-1958</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>1-11-1902</i>
9. AGE (In years last birthday) <i>36</i> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i>	
11. BIRTHPLACE (State or foreign country) <i>Fairmount, Pa.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Geo. Hagan</i>		14. MOTHER'S MAIDEN NAME <i>Lillie Duff</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT <i>Mr. Delmar Devonshire</i>		Address <i>Carrowing, Maryland</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Failure</i> <i>444 X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Uremia</i> DUE TO <i>Essential Hypertension</i> (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>5 days</i> <i>2 wks</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>Jan 52</i> to <i>Feb 9, 1958</i> that I last saw the deceased alive on <i>2/9</i> , 19 <i>58</i> , and that death occurred at <i>10A</i> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Neil Taylor</i>		ADDRESS (Street, city or town, state) <i>Rising Sun, Md.</i> DATE SIGNED <i>2/10/58</i>	
PHYSICIAN'S NAME (Type) <i>Neil Taylor Jr.</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>Jan 12, 1958</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Pleasant Grove Pa</i>	22d. LOCATION (City, town, or county) (State) <i>Peach Bottom Pa.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. Earl Tyson</i>		ADDRESS <i>Rising Sun, Md.</i>	
24a. REC'D BY REGISTRAR <i>Aw. Leach</i>		24b. REGISTRAR'S SIGNATURE <i>Aw. Leach</i>	
DATE <i>FEB 11 '58</i>			

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

1. PLACE OF DEATH		2. DATE OF DEATH	
3. NAME OF DECEASED		4. SEX	
5. AGE		6. OCCUPATION	
7. MARITAL STATUS		8. CAUSE OF DEATH	
9. PLACE OF BIRTH		10. DATE OF BIRTH	
11. NAME OF PHYSICIAN		12. SIGNATURE OF PHYSICIAN	
13. NAME OF CORONER		14. SIGNATURE OF CORONER	
15. NAME OF MINISTER		16. SIGNATURE OF MINISTER	
17. NAME OF WITNESS		18. SIGNATURE OF WITNESS	
19. NAME OF REGISTRAR		20. SIGNATURE OF REGISTRAR	
21. NAME OF CLERK		22. SIGNATURE OF CLERK	
23. NAME OF JURY		24. SIGNATURE OF JURY	
25. NAME OF JUDGE		26. SIGNATURE OF JUDGE	
27. NAME OF SHERIFF		28. SIGNATURE OF SHERIFF	
29. NAME OF DEPUTY SHERIFF		30. SIGNATURE OF DEPUTY SHERIFF	
31. NAME OF CLERK		32. SIGNATURE OF CLERK	
33. NAME OF JURY		34. SIGNATURE OF JURY	
35. NAME OF JUDGE		36. SIGNATURE OF JUDGE	
37. NAME OF SHERIFF		38. SIGNATURE OF SHERIFF	
39. NAME OF DEPUTY SHERIFF		40. SIGNATURE OF DEPUTY SHERIFF	
41. NAME OF CLERK		42. SIGNATURE OF CLERK	
43. NAME OF JURY		44. SIGNATURE OF JURY	
45. NAME OF JUDGE		46. SIGNATURE OF JUDGE	
47. NAME OF SHERIFF		48. SIGNATURE OF SHERIFF	
49. NAME OF DEPUTY SHERIFF		50. SIGNATURE OF DEPUTY SHERIFF	
51. NAME OF CLERK		52. SIGNATURE OF CLERK	
53. NAME OF JURY		54. SIGNATURE OF JURY	
55. NAME OF JUDGE		56. SIGNATURE OF JUDGE	
57. NAME OF SHERIFF		58. SIGNATURE OF SHERIFF	
59. NAME OF DEPUTY SHERIFF		60. SIGNATURE OF DEPUTY SHERIFF	
61. NAME OF CLERK		62. SIGNATURE OF CLERK	
63. NAME OF JURY		64. SIGNATURE OF JURY	
65. NAME OF JUDGE		66. SIGNATURE OF JUDGE	
67. NAME OF SHERIFF		68. SIGNATURE OF SHERIFF	
69. NAME OF DEPUTY SHERIFF		70. SIGNATURE OF DEPUTY SHERIFF	
71. NAME OF CLERK		72. SIGNATURE OF CLERK	
73. NAME OF JURY		74. SIGNATURE OF JURY	
75. NAME OF JUDGE		76. SIGNATURE OF JUDGE	
77. NAME OF SHERIFF		78. SIGNATURE OF SHERIFF	
79. NAME OF DEPUTY SHERIFF		80. SIGNATURE OF DEPUTY SHERIFF	
81. NAME OF CLERK		82. SIGNATURE OF CLERK	
83. NAME OF JURY		84. SIGNATURE OF JURY	
85. NAME OF JUDGE		86. SIGNATURE OF JUDGE	
87. NAME OF SHERIFF		88. SIGNATURE OF SHERIFF	
89. NAME OF DEPUTY SHERIFF		90. SIGNATURE OF DEPUTY SHERIFF	
91. NAME OF CLERK		92. SIGNATURE OF CLERK	
93. NAME OF JURY		94. SIGNATURE OF JURY	
95. NAME OF JUDGE		96. SIGNATURE OF JUDGE	
97. NAME OF SHERIFF		98. SIGNATURE OF SHERIFF	
99. NAME OF DEPUTY SHERIFF		100. SIGNATURE OF DEPUTY SHERIFF	

BUREAU V. S.

FEB 11 1933

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01875

1896

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>D. C.</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>16yrs. 11mo. 25days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>		d. STREET ADDRESS <b>1408 Webster Street, N.W.</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>W.</b> Last <b>DONNELLY, JR.</b>		4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1958</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-22-91</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. IF UNDER 1 YEAR Months <b>66</b> Days <b>66</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Lawyer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>New York</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James W. Donnelly Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Mary Louise McTamney</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost, (b) <b>Prostatectomy (performed 12-16-57)</b> DUE TO (c) <b>420.0</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH unknown</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 24, 1941</b> , to <b>February 18, 1958</b> , and that death occurred at <b>12:10 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. P. LACERVA</b> M.D.		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-19-58</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-19-58</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; SON</b>		ADDRESS <b>Hyvre de Grace, Md.</b>	
24a. REC'D BY REGISTRAR <b>FEB 20 '58</b>		24b. REGISTRAR'S SIGNATURE <b>W. Beach</b>	

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form No. 10

Form with multiple sections for recording death information, including fields for name, age, sex, race, date of death, and cause of death. The form is partially filled out with handwritten text.

BUREAU V. S.

FEB 20 1938

RECEIVED

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01876

## 1897 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cecilton	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Cecilton		d. STREET ADDRESS Cecilton	
3. NAME OF DECEASED (Type or print) Emma Myerly Ferguson		4. DATE OF DEATH Feb. 19 / 58 Year 19	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 22, 1866
9. AGE (In years last birthday) 92 yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life; even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME John J. Myerly		14. MOTHER'S MAIDEN NAME Harriett Oleiva Owings	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. none	
17. INFORMANT M. Alverda Ferguson, Cecilton, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 min years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) General Debility due to CVA years ago.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Jan 1, 1958, to Feb 19, 1958, that I last saw the deceased alive on Feb 19, 1958, and that death occurred at 8:30 M, from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Oberlain		M.D. Cecilton, Md. 20 Feb 58	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state) DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 22 / 58	
22c. NAME OF CEMETERY OR CREMATORY Cedilton, Cem.		22d. LOCATION (City, town, or county) (State) Cedilton, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Marvin V. Williams Chestertown, Md.		24a. REC'D BY REGISTRAR DATE FEB 25 '58	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		COUNTRY OF BIRTH	
JAMES V. S.		45		M		W		1893		BALTIMORE		BALTIMORE		MARYLAND	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
FEB 25 1958		BALTIMORE		BALTIMORE		MARYLAND		FEB 25 1958		BALTIMORE		BALTIMORE		MARYLAND	
CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION		EDUCATION		RELIGION		MARRIAGE		CHILDREN		SOURCES OF INFORMATION	
HEART DISEASE		NATURAL		LABORER		HIGH SCHOOL		METHODIST		MARRIED		3		PHYSICIAN	
DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH		COUNTRY OF DEATH	
FEB 25 1958		BALTIMORE		BALTIMORE		MARYLAND		FEB 25 1958		BALTIMORE		BALTIMORE		MARYLAND	

BUREAU V. S.

FEB 25 1958

RECEIVED

1898

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH o. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>21 yrs.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>209 Ashby</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>C</b> Last <b>HILL</b>				4. DATE OF DEATH Month <b>February</b> Day <b>18</b> Year <b>1958</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-17-97</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>		11. BIRTHPLACE (State or foreign country) <b>Texas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Richard Hill</b>				14. MOTHER'S MAIDEN NAME <b>Fanny Haregrove</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>WW I</b>		17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>unknown</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>491X</b> <b>Arteriosclerosis, generalized, moderate - unknown</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>VA</b> 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>February 19 1937</b> , to <b>February 18, 1958</b> , that I last saw the deceased <b>alive</b> , and that death occurred at <b>1:20 a M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-19-58</b>							
ACTUAL SIGNATURE <b>S. P. LACERVA</b>				PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>2/20/58</b>				22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	
22d. LOCATION (City, town, or county) (State) <b>Arlington, Virginia</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>PENNINGTON &amp; BOY</b>				ADDRESS <b>Havre de Grace, Md</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 24 '58</b>	
24b. REGISTRAR'S SIGNATURE <b>W. J. ...</b>							

MEDICAL CERTIFICATION

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
**CERTIFICATE OF DEATH**

TAKE IN 2024  
 BOND  
 CONTENT

**RECEIVED**  
 FEB 24 1958  
 BUREAU V. S.

NAME OF DECEASED [Illegible]		SEX [Illegible]		AGE [Illegible]	
DATE OF DEATH [Illegible]		TIME OF DEATH [Illegible]		PLACE OF DEATH [Illegible]	
CAUSE OF DEATH [Illegible]		MANNER OF DEATH [Illegible]		PLACE OF BIRTH [Illegible]	
OCCUPATION [Illegible]		MARITAL STATUS [Illegible]		EDUCATION [Illegible]	
SIGNATURE OF DECEASED [Illegible]		SIGNATURE OF WITNESS [Illegible]		SIGNATURE OF PHYSICIAN [Illegible]	
SIGNATURE OF CORONER [Illegible]		SIGNATURE OF JURY [Illegible]		SIGNATURE OF JUDGE [Illegible]	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01878

1899

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Narberth</b>			
c. LENGTH OF STAY IN 1b <b>5 yrs. 22 days</b>				d. STREET ADDRESS <b>222 Lanton Lane</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ANNIE</b> Middle <b>S.</b> Last <b>HUMPHREY</b>				4. DATE OF DEATH Month <b>February</b> Day <b>13</b> Year <b>19 58</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>7-9-65</b>	
9. AGE (In years last birthday) <b>92</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Nurse</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>Australia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>William Schenk - Deceased</b>				14. MOTHER'S MAIDEN NAME <b>Elizabeth Martin - Deceased</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW I</b>				16. SOCIAL SECURITY NO. <b>unknown</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease, severe</b> DUE TO (c) <b>Arteriosclerosis, generalized, severe</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2-4 days</b>  <b>unknown</b>  <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>January 22</b> , 19 <b>53</b> , to <b>February 13</b> , 19 <b>58</b> , that I last saw the deceased <b>alive</b> , and that death occurred at <b>11:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>S. P. Lacerva</i>				ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b>			
DATE SIGNED <b>2-18-58</b>							
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-18-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		22d. LOCATION (City, town, or county) (State) <b>Arlington, Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Bennington &amp; Son</i>				ADDRESS <b>Harvre de Grace, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 20 '58</b>	
24b. REGISTRAR'S SIGNATURE <i>Alfred</i>							

MEDICAL CERTIFICATION

2

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50

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1938

Page No. 13

Form with multiple fields for death certificate information, including name, date, and location. The text is mostly illegible due to blurriness.

BUREAU V. S.

FEB 20 1938

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

01879

1900

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Washington b. COUNTY D.C.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point, Md.		c. LENGTH OF STAY IN 1b 7yrs. 4mo. 10days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington, D. C.	
f. STREET ADDRESS 620 22nd St., N.W.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Melville T. Hunter		4. DATE OF DEATH Month 2-23- Day Year 19 58	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-7-88
9. AGE (In years lost birthday) yrs. 69		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Actor		10b. KIND OF BUSINESS OR INDUSTRY Theatrical	
11. BIRTHPLACE (State or foreign country) Fairfax Co. Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not ascertainable		14. MOTHER'S MAIDEN NAME Not ascertainable	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) yes WW I		16. SOCIAL SECURITY NO. 148-03-9026	
17. INFORMANT Hospital Records, VAH, Perry Point, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 260x Bronchopneumonia DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Diabetes Mellitus DUE TO (c) Cerebral embolism hemiplegia left complete		INTERVAL BETWEEN ONSET AND DEATH Approx. 2 days unknown unknown	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491x		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. VA 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 10-13-50, 19, to 2-23-1958, and that death occurred at 9:50AM, from the causes and on the date stated above.			
ACTUAL SIGNATURE S. P. IACERVA		DATE SIGNED 2-24-58	
PHYSICIAN'S NAME (Type) S. P. IACERVA, M.D. Director, Professional Services		ADDRESS (Street, city or town, state) VA Hospital, Perry Point, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF 2/27/58	22c. NAME OF CEMETERY OR CREMATORY Arlington National	22d. LOCATION (City, town, or county) (State) Arlington, Virginia
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son		ADDRESS Havre de Grace, Md.	
24a. REC'D BY REGISTRAR DATE MAR 4 '58		24b. REGISTRAR'S SIGNATURE	

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1901

CERTIFICATE OF DEATH

Reg. Dist. No.

96

01880

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>				c. LENGTH OF STAY IN 1b <b>15yrs.5mo.12days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Baltimore</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Veterans Administration Hospital</b>				d. STREET ADDRESS <b>2007 Ruxton Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAM</b> Middle <b>(NMI)</b> Last <b>JENKINS</b>				4. DATE OF DEATH Month <b>February</b> Day <b>11</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-1-93</b>		9. AGE (In years last birthday) <b>64</b> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>unknown</b>		11. BIRTHPLACE (State or foreign country) <b>South Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I</b>		17. INFORMANT Address <b>Hospital Records, VAH, Perry Point, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, right lower lobe unresolved</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic brain syndrome of uncertain cause</b> DUE TO (c) <b>Arteriosclerosis generalized severe</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3-4 days</b> <b>unknown</b> <b>unknown</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. <b>19</b> p. m. <b>VA</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 29, 1942</b> , to <b>February 11, 1958</b> , that I know the deceased, and that death occurred at <b>7:15 a.m.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. M. HARRIS</b>		ADDRESS (Street, city or town, state) <b>V.A. Hospital, Perry Point, Md.</b> DATE SIGNED <b>2-11-58</b>					
PHYSICIAN'S NAME (Type) <b>W. M. HARRIS</b>		Acting Director, Professional Services					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>2-12-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b> ADDRESS <b>Havre de Grace, Md.</b>				24a. REC'D BY REGISTRAR <b>FEB 18 58</b> DATE		24b. REGISTRAR'S SIGNATURE	

CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH		CITY OF BIRTH		STATE OF BIRTH		COUNTRY OF BIRTH	
JAMES H. HARRIS		45		M		W		1880		BALTIMORE		MD		MD		USA	
MARRIAGE		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF DEATH		PLACE OF DEATH		CITY OF DEATH	
MARRIED		1905		BALTIMORE		MD		MD		USA		FEB 18 1933		BALTIMORE		MD	
CAUSE OF DEATH		DISEASE		COMPLICATIONS		TREATMENT		PHYSICIAN		HOSPITAL		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION	
HEART DISEASE		CORONARY ARTERY DISEASE		HYPERTENSION		MEDICINE		DR. J. H. HARRIS		BALTIMORE		FEB 18 1933		BALTIMORE		MD	
MANNER OF DEATH		NATURAL		ACCIDENT		SUICIDE		UNNATURAL		DATE OF BURIAL		PLACE OF BURIAL		CITY OF BURIAL		STATE OF BURIAL	
NATURAL		NATURAL		NATURAL		NATURAL		NATURAL		FEB 18 1933		BALTIMORE		MD		MD	
SIGNATURE OF PHYSICIAN		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION	
J. H. HARRIS		FEB 18 1933		BALTIMORE		MD		MD		USA		FEB 18 1933		BALTIMORE		MD	
SIGNATURE OF REGISTRAR		DATE		PLACE		CITY		STATE		COUNTRY		DATE OF EXAMINATION		PLACE OF EXAMINATION		CITY OF EXAMINATION	
J. H. HARRIS		FEB 18 1933		BALTIMORE		MD		MD		USA		FEB 18 1933		BALTIMORE		MD	

BUREAU V. S.

FEB 18 1933

RECEIVED



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

01881

Reg. Dist. No.

1878

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton				c. LENGTH OF STAY IN 1b Life			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 119 Bow St.				d. STREET ADDRESS 119 Bow St.			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last Rebecca H. Jones				4. DATE OF DEATH February 12 19 58			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Mar. 11, 1875	
9. AGE (In years last birthday) 82 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY at Home		11. BIRTHPLACE (State or foreign country) Elkton, Md.	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME John B. Heath				14. MOTHER'S MAIDEN NAME Margaret J. Crowe			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No				16. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Harriet J. George	
Address Elkton, Md.							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 422.1 DUE TO Acute cerebrovascular accident Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260X diabetes INTERVAL BETWEEN ONSET AND DEATH unknown 48 hours							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Jan. 13, 19 58, to Feb. 12, 19 58, that I last saw the deceased alive on Feb. 11, 19 58, and that death occurred at 8:00 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. Ralph Andrews, Jr., M.D.				ADDRESS (Street, city or town, state) 233 E. Main Street Elkton Maryland			
DATE SIGNED Feb. 12, 1958							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 2/15/58		22c. NAME OF CEMETERY OR CREMATORY Elkton Cemetery	
22d. LOCATION (City, town, or county) (State) Elkton, Maryland							
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home				ADDRESS Donald H. Lee Elkton, Md.		24a. REC'D BY REGISTRAR FEB 14 '58	
24b. REGISTRAR'S SIGNATURE							

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. 81

1953 7 8

RECEIVED

1879

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>CECIL</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>NEWCASTLE</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELKTON</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>1114 CAPITOL TRAIL NEWARK</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>UNION HOSPITAL</u>		d. STREET ADDRESS <u>1114 CAPITOL TRAIL</u> 46 X-3	
3. NAME OF DECEASED (Type or print) <u>HENRY P. KRAJEWSKI</u>		4. DATE OF DEATH Month <u>FEB.</u> Day <u>6</u> Year <u>1958</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>OCT. 14, 1922</u> 33 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>TOOL &amp; DIE MAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>AUTO INDUSTRY</u>	
11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>DALMAZY KRAJEWSKI</u>		14. MOTHER'S MAIDEN NAME <u>MICHALINA STANCZAK</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>YES</u> <u>WW II</u>		16. SOCIAL SECURITY NO. <u>WW II</u>	
17. INFORMANT <u>MRS. ALICE KRAJEWSKI</u>		Address <u>1114 CAPITOL TRAIL NEWARK, DEL.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Rupture of the Aorta</u> 451X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Spontaneous medial necrosis of the aorta</u> DUE TO (c) <u>Unknown</u>			INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>1-5</u> , 1958, to <u>2-6</u> , 1958, that I last saw the deceased alive on <u>2-5</u> , 1958, and that death occurred at <u>3 A.M.</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>William Eppes</u> M.D.		ADDRESS (Street, city or town, state) <u>325 E main street Newark, Del.</u>	
PHYSICIAN'S NAME (Type)		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	22b. DATE THEREOF <u>2/10/58</u>	22c. NAME OF CEMETERY OR CREMATORY <u>CATHEDRAL CEM.</u>	22d. LOCATION (City, town, or county) (State) <u>WILMINGTON DEL</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>PIPPIN FUNERAL HOME</u>		ADDRESS <u>Donnell Dr. ELKTON, MD</u>	
24a. REC'D BY REGISTRAR <u>Feb 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. Eppes</u>	

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THE LOW REQUIRES THAT THE DEATH CERTIFICATE BE EXECUTED WITHIN 24 HOURS AFTER DEATH. THE REGISTRAR PRIOR TO BURIAL, CREMATION, OR REMOVAL, AND IN ANY EVENT WITHIN 72 HOURS AFTER DEATH.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. The registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

# CERTIFICATE OF DEATH

See last page

NAME: **DAVID KRATZEWski**  
 SEX: **MALE**  
 RACE: **WHITE**  
 DATE OF BIRTH: **1915**  
 PLACE OF BIRTH: **NEW YORK**  
 DEATH DATE: **FEB 10 1958**  
 DEATH PLACE: **NEW YORK**  
 CAUSE OF DEATH: **HEART DISEASE**  
 MEDICAL HISTORY: **NO**  
 OCCUPATION: **TOY AND DIE MAKER AUTO INDUSTRY**  
 RELIGION: **YES**  
 MARRIAGE: **YES**  
 SPOUSE: **MRS. ALICE KRATZEWski**  
 CHILDREN: **MICHAEL, STANISLAW**  
 US citizen: **YES**

**BUREAU V. 3**

**FEB 10 1958**

**RECEIVED**

**2/10/58**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01883

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

1 1902

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY A.D.			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perry Point				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis			
c. LENGTH OF STAY in 1b 2yrs. 1mo. 8days				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Veterans Administration Hospital				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First BENJAMIN Middle H. Last LARRIMORE			4. DATE OF DEATH Month February Day 9 Year 19 58				
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 10-8-1870		9. AGE (In years last birthday) 87		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unknown		10b. KIND OF BUSINESS OR INDUSTRY unknown		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Richard Larrimore				14. MOTHER'S MAIDEN NAME Mary Anne Harrison			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes WW I		16. SOCIAL SECURITY NO. unknown		17. INFORMANT Address Hospital Records, VAH, Perry Point, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia, bilateral, severe 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis generalized, severe DUE TO (c) unknown PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 491X							INTERVAL BETWEEN ONSET AND DEATH 7 days
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. p. m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-1-1955, to February 9, 1958, and that death occurred at 6:20 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE S. P. LACERVA				ADDRESS (Street, city or town, state) V.A. Hospital, Perry Point, Md. DATE SIGNED 2-11-58			
PHYSICIAN'S NAME (Type) S. P. LACERVA				Director, Professional Services			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 2-13-58		22c. NAME OF CEMETERY OR CREMATORY Baltimore National		22d. LOCATION (City, town, or county) (State) Baltimore, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pennington & Son, Havre de Grace, Md.				24a. REC'D BY REGISTRAR DATE FEB 18 '58		24b. REGISTRAR'S SIGNATURE	

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.







TO DEPUTY REGISTRAR: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 01884

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D.		c. LENGTH OF STAY IN 1b All life	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dutch Town Crossing, P.R.R. Cros		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East	
f. STREET ADDRESS 49 Walnut St.		g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Leon Eugene Lockard		4. DATE OF DEATH Month 2 Day 28 Year 19 58	
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-6-1941
9. AGE (In years last birthday) 16 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) North East, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Leon Reese Lockard		14. MOTHER'S MAIDEN NAME Anna Mae Raine	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----	
17. INFORMANT Anna M. Lockard, North East, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Fracture both arms Partial amputation 810 X DUE TO of both lower legs Crushed Head with loss of Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO brain tissue (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in car hit by train at crossing	
20c. TIME OF INJURY Month, Day, Year 5-5-58 2 28 19 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) R.R. Crossing		20f. (City or town) North East, R.D. Cecil Md (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE R.C. Dodson		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) R.C. Dodson		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 3-1-58	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-58	
22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) North East Cecil, Md (State)	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph R. Grant North East Md		ADDRESS	
24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
DATE MAR 4 '58		REMARKS	

BUREAU V. S.

MAR 7 1953

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01885

Items 3 &amp; 7 Film G227, 4/11/58 fcy

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>NewCastle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>		e. STREET ADDRESS <b>Apple Grove Court</b>	
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>James</b> Last <b>Thomas Marshall</b>		4. DATE OF DEATH Month <b>2</b> Day <b>7</b> Year <b>19 58</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-11-1931</b>
9. AGE (in years last birthday) <b>27</b> yrs.		10. IF UNDER 1 YEAR Months / Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chrysler Plant</b>	
11. BIRTHPLACE (State or foreign country) <b>Sparta, Tenn</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Pine Marshall</b>		14. MOTHER'S MAIDEN NAME <b>Parrey Lee Eller</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Korea</b>		16. SOCIAL SECURITY NO. <b>413-46-9432</b>	
17. INFORMANT <b>Mrs. J.T. Marshall, Bear, Del.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fractured skull and Jaw , lacerated right side:</b> 816x DUE TO <b>of face evulsion of right eyeball crushed chest.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car ran under a trailer</b>	
20c. TIME OF INJURY Month, Day, Year <b>7.25</b> p. m. <b>17</b> 19 <b>58</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) (County) (State) <b>Elkton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		DATE SIGNED <b>2-8-58</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>	22b. DATE THEREOF <b>Feb. 9, 1958</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Browntown Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Browntown Tenn.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>		24a. REC'D BY REGISTRAR <b>W. H. Redman</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate with the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Thomas Marshall	
Residence		Appl's Grove Court	
Age		27	
Sex		Male	
Race		White	
Occupation		Auto worker	
Cause of Death		Fractured skull and jaw, lacerated right side of face resulting of right eyeball crushed chest.	
Date of Death		11-11-1931	
Place of Death		Home	
Signature of Physician		J. T. Marshall, M.D.	
Signature of Medical Examiner		J. T. Marshall, M.D.	

Car ran under a trailer

17 58

BUREAU V. S.

FEB 13 1933

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01886

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Cecil; 1974 MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) o. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East R.D.		c. LENGTH OF STAY IN 1b all life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X North East			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Dutch Towb P.R.R. Crossing				d. STREET ADDRESS 49 Walnut St.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Rex First Leon Middle Mc Barnes Last				4. DATE OF DEATH Month 2 Day 28 Year 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 11-10-1956		9. AGE (In years last birthday) 15 yrs.	IF UNDER 1 YEAR Months 5 Days 15
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Infant		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Elkton, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Rex David Mc Barnes				14. MOTHER'S MAIDEN NAME Icelena Lockard North East, Md.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. -----		17. INFORMANT Rex D. Mc Barnes, North East, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 810 X Crushed Skull with loss of brain tissue. DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH _____							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Was in car hit by train					
20c. TIME OF INJURY Month, Day, Year Hour 5:55 P. m. 2 28 58		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) B.R. Crossing		20f. (City or town) North East Cecil (County) (State) Md.	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) R. C. Dodson				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 3-3-58		22c. NAME OF CEMETERY OR CREMATORY Methodist		22d. LOCATION (City, town, or county) North East Cecil (State) Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph P. Hunt North East Md				24a. REC'D BY REGISTRAR DATE MAR 4 '58		24b. REGISTRAR'S SIGNATURE A. Deane	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

DATE OF DEATH

TIME OF DEATH

PLACE OF DEATH

AGE

SEX

CAUSE OF DEATH

MANNER OF DEATH

PLACE OF BURIAL

NAME OF FUNERAL HOME

DATE

TIME

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BUREAU V. S.

MAR 7 1958

RECEIVED



## 1905 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) North East				c. LENGTH OF STAY IN 1b Lifetime			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last Lola Viola McKinney				4. DATE OF DEATH Month Day Year Feb 16 1958			
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1889		9. AGE (In years last birthday) 68 yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) North East (Rural)		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John Thomas Moore				14. MOTHER'S MAIDEN NAME Catherine Stewart			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None		17. INFORMANT Edgar R. McKinney North East, Maryland			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 Coronary Occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH 30 days 10 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. _____ 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from May, 1946, to Feb. 16, 1958, that I last saw the deceased alive on Feb. 15, 1958, and that death occurred at 8:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Hueckner M.D.				ADDRESS (Street, city or town, state) North East, Md.			
DATE SIGNED 16 Feb '58							
PHYSICIAN'S NAME (Type) Klaus H. Hueckner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 20, 1958		22c. NAME OF CEMETERY OR CREMATORY Methodist Cemetery		22d. LOCATION (City, town, or county) (State) North East, Cecil Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Joseph A. Grant				ADDRESS North East, Maryland		24a. REC'D BY REGISTRAR DATE FEB 20 '58	
				24b. REGISTRAR'S SIGNATURE R. L. Search			

MEDICAL CERTIFICATION

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. DATE OF BIRTH	
5. PLACE OF BIRTH		6. OCCUPATION		7. CAUSE OF DEATH		8. MANNER OF DEATH	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. SIGNATURE OF PHYSICIAN	
13. SIGNATURE OF REGISTRAR		14. SIGNATURE OF WITNESS		15. SIGNATURE OF DECEASED		16. SIGNATURE OF NEXT OF KIN	
17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF CHURCH OFFICIAL		19. SIGNATURE OF FUNERAL HOME		20. SIGNATURE OF CEMETERY	
21. SIGNATURE OF HEALTH DEPARTMENT		22. SIGNATURE OF COUNTY CLERK		23. SIGNATURE OF CITY CLERK		24. SIGNATURE OF STATE CLERK	
25. SIGNATURE OF FEDERAL CLERK		26. SIGNATURE OF POSTAL CLERK		27. SIGNATURE OF MARINE CLERK		28. SIGNATURE OF AIR FORCE CLERK	
29. SIGNATURE OF NAVY CLERK		30. SIGNATURE OF ARMY CLERK		31. SIGNATURE OF AIR FORCE CLERK		32. SIGNATURE OF MARINE CLERK	
33. SIGNATURE OF COAST GUARD CLERK		34. SIGNATURE OF CUSTOMS CLERK		35. SIGNATURE OF IMMIGRATION CLERK		36. SIGNATURE OF NATURALIZATION CLERK	
37. SIGNATURE OF DEPARTMENT OF JUSTICE		38. SIGNATURE OF DEPARTMENT OF AGRICULTURE		39. SIGNATURE OF DEPARTMENT OF COMMERCE		40. SIGNATURE OF DEPARTMENT OF EDUCATION	
41. SIGNATURE OF DEPARTMENT OF HEALTH		42. SIGNATURE OF DEPARTMENT OF LABOR		43. SIGNATURE OF DEPARTMENT OF MINES		44. SIGNATURE OF DEPARTMENT OF TRANSPORTATION	
45. SIGNATURE OF DEPARTMENT OF WAR		46. SIGNATURE OF DEPARTMENT OF THE INTERIOR		47. SIGNATURE OF DEPARTMENT OF THE ARMY		48. SIGNATURE OF DEPARTMENT OF THE NAVY	
49. SIGNATURE OF DEPARTMENT OF THE AIR FORCE		50. SIGNATURE OF DEPARTMENT OF THE MARINE CORPS		51. SIGNATURE OF DEPARTMENT OF THE COAST GUARD		52. SIGNATURE OF DEPARTMENT OF THE CUSTOMS	
53. SIGNATURE OF DEPARTMENT OF THE IMMIGRATION		54. SIGNATURE OF DEPARTMENT OF THE NATURALIZATION		55. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF JUSTICE		56. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF AGRICULTURE	
57. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF COMMERCE		58. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF EDUCATION		59. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF HEALTH		60. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF LABOR	
61. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF MINES		62. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF TRANSPORTATION		63. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF WAR		64. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE INTERIOR	
65. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE ARMY		66. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE NAVY		67. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE AIR FORCE		68. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE MARINE CORPS	
69. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE COAST GUARD		70. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE CUSTOMS		71. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE IMMIGRATION		72. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE NATURALIZATION	
73. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF JUSTICE		74. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF AGRICULTURE		75. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF COMMERCE		76. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF EDUCATION	
77. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF HEALTH		78. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF LABOR		79. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF MINES		80. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF TRANSPORTATION	
81. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF WAR		82. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE INTERIOR		83. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE ARMY		84. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE NAVY	
85. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE AIR FORCE		86. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE MARINE CORPS		87. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE COAST GUARD		88. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE CUSTOMS	
89. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE IMMIGRATION		90. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE NATURALIZATION		91. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF JUSTICE		92. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF AGRICULTURE	
93. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF COMMERCE		94. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF EDUCATION		95. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF HEALTH		96. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF LABOR	
97. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF MINES		98. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF TRANSPORTATION		99. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF WAR		100. SIGNATURE OF DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE DEPARTMENT OF THE INTERIOR	

BUREAU V. S.

FEB 20 1958

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**  
**1881**

Reg. Dist. No.

01888

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del.</b> b. COUNTY <b>New Castle</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>D.O.A.</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>George Jr. McMurry</b>				4. DATE OF DEATH Month Day Year <b>2 7 1958</b>			
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>8-3-1931</b>	
9. AGE (In years last birthday) <b>26</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Alabama</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto. Worker</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Chrysler</b>			
13. FATHER'S NAME <b>George J. Mc Murrey Sr.</b>				14. MOTHER'S MAIDEN NAME <b>Myrtle</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16. SOCIAL SECURITY NO. <b>424-34-5880</b>		17. INFORMANT <b>Bertha McMurry, Stevenson, Ala.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lacerated right side of face fractured skull and</b>  <b>816X</b>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.            (b) <b>lower jaw, laceration left lower leg and crushed chest.</b>            DUE TO            (c) _____</p> </div> <div style="width: 35%; text-align: center;"> <p>INTERVAL BETWEEN ONSET AND DEATH</p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <p>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>  <b>Car ran under a Tractor Trailer Truck</b></p> </div> <div style="width: 35%;"> <p>19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/></p> </div> </div>							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car ran under a Tractor Trailer Truck</b>				20c. TIME OF INJURY Month, Day, Year <b>7.25 2 7 1958</b>			
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40 Elkton Cecil Md.</b>			
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <i>R.C. Dodson</i>				DATE SIGNED <b>2-8-57</b>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Feb. 11, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Stevenson, Alabama</b>		22d. LOCATION (City, town, or county) (State) <b>Alabama</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Pippin Funeral Home</i>				24a. REC'D BY REGISTRAR <b>FEB 14 58</b>			
ADDRESS <b>Elkton, Md.</b>				24b. REGISTRAR'S SIGNATURE <i>W. H. Hedrick</i>			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
George J. Harrison		312 N. Harrison		Male		White		1931-3-1		Baltimore, Md.	
Occupation		Cause of Death		Manner of Death		Signature of Physician		Signature of Medical Examiner		Date of Examination	
None		Hypertension		Natural		[Signature]		[Signature]		1931-3-1	

Post-mortem examination of the body of the deceased revealed the following conditions: Lacerated right side of face, fractured skull and lower jaw, laceration left lower leg and crushed chest.

Car was under a Trenton Towler Truck

BURMAN Y. B.

FEB 1 1932

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1882

CERTIFICATE OF DEATH

Reg. Dist. No. 01889

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 5 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Conowingo Rural		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Lawrence Miller				4. DATE OF DEATH Month Day Year Feb. 11 1958			
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 15, 1889		9. AGE (In years lost birthday) 68 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Laborer		10b. KIND OF BUSINESS OR INDUSTRY common Laborer		11. BIRTHPLACE (State or foreign country) Darlington Md.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME John Emrey Miller				14. MOTHER'S MAIDEN NAME Annie Matilda Rice			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY NO.		17. INFORMANT Annie Boyer Conowingo, Md. Rural			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cirrhosis of Liver 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 7 months	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. — 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb. 6, 1958, to Feb. 11, 1958, that I last saw the deceased alive on Feb. 11, 1958, and that death occurred at 7:30 A.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Klaus H. Huchner				ADDRESS (Street, city or town, state) North E. & Rd.		DATE SIGNED Feb. 11, 1958	
PHYSICIAN'S NAME (Type) Klaus H. Huchner M.D.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Feb. 15, 1958		22c. NAME OF CEMETERY OR CREMATORY Oak Grove Cem		22d. LOCATION (City, town, or county) (State) Conowingo Md	
23. FUNERAL DIRECTOR'S SIGNATURE J. Earl Tyson, Rising Sun, Md.				24a. REC'D BY REGISTRAR FEB 14 '58		24b. REGISTRAR'S SIGNATURE [Signature]	

CERTIFICATE OF DEATH

1892

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH		PLACE OF BIRTH		CITY		COUNTY		STATE	
JAMES H. HARRIS		Male		45		1847		Maryland		Baltimore		Baltimore		Maryland	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH		PERIOD OF ILLNESS		DATE OF DEATH		PLACE OF DEATH		CITY		COUNTY	
Carpenter		Heart Disease		Natural		Several Months		Feb 12, 1892		Baltimore		Baltimore		Maryland	
FATHER'S NAME		MOTHER'S NAME		MARRIAGE		EDUCATION		RELIGION		SPECIAL INSTRUCTIONS		SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES	
James H. Harris		Mary H. Harris		1865		Common School		Roman Catholic							
DATE OF INTERMENT		PLACE OF INTERMENT		CITY		COUNTY		STATE		SIGNATURE OF MINISTER		SIGNATURE OF CLERGYMAN		SIGNATURE OF RABBI	
Feb 14, 1892		St. Mary's Church		Baltimore		Baltimore		Maryland		James H. Harris		John H. Harris		John H. Harris	

BUREAU V. S.

FEB 14 1938

RECEIVED



1883

## CERTIFICATE OF DEATH

01890

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Cecil</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Elkton</u>		c. LENGTH OF STAY IN 1b <u>Life</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>257 Mackall St</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Irvin</u> Middle <u>Lee</u> Last <u>Moore</u>		4. DATE OF DEATH Month <u>February</u> Day <u>27</u> Year <u>1958</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 8, 1887</u>
9. AGE (In years last birthday) <u>70</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>3</u> Days <u>2</u> Hours <u>3</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farmer Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farming</u>	
11. BIRTHPLACE (State or foreign country) <u>Elkton, md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>James M. Moore</u>		14. MOTHER'S MAIDEN NAME <u>Annie McNeal</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>No</u>	
17. INFORMANT <u>Ada M. Slaughter</u>		18. ADDRESS <u>257 Mackall St. Elkton, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular accident</u> <u>422.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO (c) <u>unknown</u>		INTERVAL BETWEEN ONSET AND DEATH <u>3 1/2 months</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour <u>19</u> p. m.		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>Nov. 16, 1957</u> to <u>Feb. 27, 1958</u> , that I last saw the deceased alive on <u>Feb. 22, 1958</u> , and that death occurred at <u>1 P. M.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>S. Ralph Andrews, Jr.</u> M.D.		ADDRESS (Street, city or town, state) <u>233 E. Main St. Elkton Maryland</u>	
PHYSICIAN'S NAME (Type) <u>S. Ralph Andrews, Jr., M.D.</u>		DATE SIGNED <u>Feb. 28, 1958</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>3-2-1958</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Elkton Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Elkton Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Pippin Funeral Home Donald M. Dee</u>		24a. REC'D BY REGISTRAR <u>Mar 5 '58</u>	
24b. REGISTRAR'S SIGNATURE <u>Dee</u>			

MEDICAL CERTIFICATION

TO HOSPITAL: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

PLACE OF DEATH COUNTY _____		DECEASED NAME _____	
A. DATE OF DEATH _____ TIME OF DEATH _____		B. SEX _____ AGE _____	
C. RACE _____ COLOR _____		D. OCCUPATION _____	
E. PLACE OF BIRTH _____ DATE OF BIRTH _____		F. PLACE OF DEATH _____ DATE OF DEATH _____	
G. CAUSE OF DEATH _____ (Specify) _____		H. MANNER OF DEATH _____ (Specify) _____	
I. NAME OF PHYSICIAN _____ ADDRESS _____		J. NAME OF CORONER _____ ADDRESS _____	
K. NAME OF FUNERAL HOME _____ ADDRESS _____		L. NAME OF BURIAL PLACE _____ ADDRESS _____	
M. NAME OF NEXT OF KIN _____ ADDRESS _____		N. NAME OF WITNESS _____ ADDRESS _____	
O. NAME OF WITNESS _____ ADDRESS _____		P. NAME OF WITNESS _____ ADDRESS _____	
Q. NAME OF WITNESS _____ ADDRESS _____		R. NAME OF WITNESS _____ ADDRESS _____	
S. NAME OF WITNESS _____ ADDRESS _____		T. NAME OF WITNESS _____ ADDRESS _____	
U. NAME OF WITNESS _____ ADDRESS _____		V. NAME OF WITNESS _____ ADDRESS _____	
W. NAME OF WITNESS _____ ADDRESS _____		X. NAME OF WITNESS _____ ADDRESS _____	
Y. NAME OF WITNESS _____ ADDRESS _____		Z. NAME OF WITNESS _____ ADDRESS _____	

BUREAU V. 2

RECEIVED

1933

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 1958 CERTIFICATE OF DEATH

Reg. Dist. No. 01891

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville, Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Perryville Rural	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jackson Station Road		d. STREET ADDRESS Jackson Station Road	
3. NAME OF DECEASED (Type or print) Margaret Ann Nickle		4. DATE OF DEATH Feb. 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 3-29-1870
9. AGE (In years last birthday) yrs. 87		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Wife	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME William T. Wilson		14. MOTHER'S MAIDEN NAME Sarah Murphy	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO.	
17. INFORMANT Address Miss Florence Nickle, Perryville, Md. R			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 331X Cerebral Hemorrhage (Paralytic) DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerosis - DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 1 day 10 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Myocarditis.		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb-8, 1958, to Feb-18, 1958, that I last saw the deceased alive on Feb-18, 1958, and that death occurred at 1:15 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Clarence I. Benson M.D.		ADDRESS (Street, city or town, state) Port Deposit, Md. DATE SIGNED 2/20/58	
22a. BURIAL, CREMATION, or other disposal (Specify) Burial		22b. DATE THEREOF 2-21-1958	
22c. NAME OF CEMETERY OR CREMATORY Principio		22d. LOCATION (City, town, or county) (State) Principio Furnace, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Lee A. Patterson & Son, Perryville, Md.		24a. REC'D BY REGISTRAR DATE FEB 24 '58	
24b. REGISTRAR'S SIGNATURE			

CERTIFICATE OF DEATH

Name of Deceased		Johnston, William	
Age		45	
Sex		Male	
Race		White	
Marital Status		Married	
Date of Death		February 24, 1959	
Place of Death		Home	
Cause of Death		Heart Disease	
Occupation		Teacher	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

BURKAV Y. E.

FEB 24 1959

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01892

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Ky.</b> b. COUNTY <b>Floyd</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b <b>36 hours</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Betsy Lane</b> 55X-3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>William Howard Senters</b>				4. DATE OF DEATH Month Day Year <b>2 9 1958</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4-10-1927</b>		9. AGE (In years last birthday) <b>30 yrs.</b>	IF UNDER 1 YEAR Months Days <b>30</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto. Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Chrysler Corp.</b>		11. BIRTHPLACE (State or foreign country) <b>Ken.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Carl Lee Senters</b>				14. MOTHER'S MAIDEN NAME <b>Ethel Miller</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>W.W.2 401-34-5967</b>		17. INFORMANT Address <b>Clyde Senters, Pikeville, Ky.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Concussion, Fracture of nasal and face bones and lower third of fibula. Multiple lacerations of the face and tongue</b> 816X DUE TO <b>extensor tendon of left 5th finger nasal hemorrhage</b> Conditions, if any, which gave rise to immediate cause (b) <b>contusions of the eyes and cheeks.</b> (c) <b>stotting the underlying</b> cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Car ran under a tractor trailer</b>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car ran under a tractor trailer</b>					
20c. TIME OF INJURY Month, Day, Year <b>7.25 a.m. 2 7 19 58</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>		20f. (City or town) (County) (State) <b>Elkton Cecil Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>R.C. Dodson</b>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>				22b. DATE THEREOF <b>2-10-58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pikeville, Kentucky</b>	
22d. LOCATION (City, town, or county) (State) <b>Pikeville, Kentucky</b>				24a. REC'D BY REGISTRAR <b>FEB 13 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Alfred</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pizzari Funeral Home Small 120 Elkton, Md</b>							

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased Cecil		Sex Male		Age 30 years		Date of Death 1-10-1927		Place of Death Baltimore, Md.	
Name of Physician William Howard		Name of Hospital Union Hospital		Name of Doctor Betsy Lane		Name of Nurse Howard		Name of Undertaker Betsy Lane	
Cause of Death Auto. Worker		Occupation Cigarette Corp.		Residence Ken.		U.S.A.		Date of Birth 1-10-1927	
Name of Coroner Carl Lee Sanders		Name of Medical Examiner Edw. I. Miller		Name of Assistant Medical Examiner W. W. S.		Date of Examination 1-10-1927		Place of Examination Baltimore, Md.	
General Condition: Fracture of nasal and face bones and lower third of tibia. Multiple lacerations of the face and tongue. Extensor tendon of left 5th finger nasal hemorrhage. contusions of the eyes and cheeks.									
Can you under a greater condition 1.25 1 7 20 X Route 10 Winton Cecil X									
RECEIVED FEB 13 1928 BUREAU V. S.									



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1885

01893

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 3 yrs		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Newark, R.D. 2 Del.			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital. D.O.A.				d. STREET ADDRESS /		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last Frank Henderson Slocum				4. DATE OF DEATH Month Day Year 2 22 19 58			
5. SEX M	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 9-26-1882		9. AGE (In years last birthday) 75 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Po. Eng.		10b. KIND OF BUSINESS OR INDUSTRY Portable Engineer		11. BIRTHPLACE (State or foreign country) Danby, N.Y.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Tjeron W. Slocum				14. MOTHER'S MAIDEN NAME Ella McGillivray			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) 085-12-7742		17. INFORMANT Mrs. Frank Slocum, Newark, R.D. 2 Del.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause lost. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R. C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R. C. Dodson				DATE SIGNED 2-22-58			
22a. BURIAL, CREMATION, REMOVAL (Specify) REMOVAL		22b. DATE THEREOF 2/24/58		22c. NAME OF CEMETERY OR CREMATORY KING CEMETERY		22d. LOCATION (City, town, or county) (State) ITHICA, NEW YORK	
23. FUNERAL DIRECTOR'S SIGNATURE PIPPIN FUNERAL HOME				ADDRESS Somerset, Del.		24a. REC'D BY REGISTRAR FEB 26 '58	
				24b. REGISTRAR'S SIGNATURE W. H. ...			

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Give Page 4 to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: OR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAXY AND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

FEB 26 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1886

## CERTIFICATE OF DEATH

Reg. Dist. No. 01894

1. PLACE OF DEATH a. COUNTY Cecil MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton			c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Elkton, Md. R.D.#4		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital				d. STREET ADDRESS 1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Edith		First Edith		Middle B.		4. DATE OF DEATH Month February Day 23 Year 19 58	
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Aug. 21, 1882	
9. AGE (In years lost birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) Pennsylvania	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Richard B. Mars				14. MOTHER'S MAIDEN NAME Margaret Jane Clark			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. [redacted]		17. INFORMANT Vaughn M. Spence			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 260x Diabetes mellitus, severe URT.		ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 10 min.			
ACUTE CORONARY THROMBOSIS		10 min.					
CORONARY ARTERIOSCLEROSIS		2-3 yrs.					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2.6, 1958, to 2.23, 1958, that I last saw the deceased alive on 2.23, 1958, and that death occurred at 11:55 AM, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED PETER STAVRAKIS M.D. 154 W. MAIN 2.24.58 PHYSICIAN'S NAME (Type) PETER STAVRAKIS ELKTON, Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/26/58		22c. NAME OF CEMETERY OR CREMATORY Cherry Hill Cemetery		22d. LOCATION (City, town, or county) (State) Cherry Hill, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Ralph E. Hicks		ADDRESS Elkton, Md.		24a. REC'D BY REGISTRAR DATE FEB 28 '58		24b. REGISTRAR'S SIGNATURE [Signature]	



TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1887

## CERTIFICATE OF DEATH

Reg. Dist. No. 01895

1. PLACE OF DEATH a. COUNTY Cecil, MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Md. b. COUNTY Cecil	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton		c. LENGTH OF STAY IN 1b 11 days	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Union Hospital		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X Chesapeake City	
3. NAME OF DECEASED (Type or print) First Lucy Middle G. Last Stapp		4. DATE OF DEATH Month Feb. Day 12, Year 19 58	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Sept. 20, 1897
9. AGE (In years last birthday) 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Deputy Clerk,		10b. KIND OF BUSINESS OR INDUSTRY Cecil County	
11. BIRTHPLACE (State or foreign country) Chesapeake City, Md.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Edward Stapp		14. MOTHER'S MAIDEN NAME Mary Krastel	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. (If yes, give year or dates of service) none	
17. INFORMANT Charles Stapp, Chesapeake City, Md.		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 coronary occlusion DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 7 min. year	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from Feb 5, 1958, to Feb 12, 1958, that I last saw the deceased alive on Feb 12, 1958, and that death occurred at 6:50 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Wallace Osherman M.D.		ADDRESS (Street, city or town, state) DATE SIGNED Chesapeake City, Md. 13 Feb 58	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2-15-58	
22c. NAME OF CEMETERY OR CREMATORY St. Roses		22d. LOCATION (City, town, or county) (State) Chesapeake City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Pippin Funeral Home		ADDRESS Elkton, Md.	
24a. REC'D BY REGISTRAR DATE FEB 18 58		24b. REGISTRAR'S SIGNATURE	



CERTIFICATE OF DEATH

BUREAU V. 31

FEB 18 1966

RECEIVED

TO HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

01896

1888

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Cecil</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elk Mills</b>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>1</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Howard T. Stigile</b>				4. DATE OF DEATH Month Day Year <b>Feb. 12, 1958 19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 18, 1899</b>		9. AGE (In years lost birthday) yrs. <b>59</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Machinist</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Linford Stigile</b>				14. MOTHER'S MAIDEN NAME <b>No record</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>221-07-5376</b>		17. INFORMANT <b>Mrs. Reba M. Stigile</b>		Address <b>Elk Mills, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute coronary thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerotic cardiovascular disease unknown</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>14 hours</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year <b>19</b>		20d. INJURY OCCURRED White of work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>August 14, 1953</b> , to <b>Feb. 12, 1958</b> , that I last saw the deceased alive on <b>Feb. 12, 1958</b> , and that death occurred at <b>6 p. M.</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>S. Ralph Andrews, Jr.</b>				ADDRESS (Street, city or town, state) <b>233 E. Main St., Elkton, Md.</b>		DATE SIGNED <b>2/12/58</b>	
PHYSICIAN'S NAME (Type) <b>S. Ralph Andrews, Jr., M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Feb. 15, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Cherry Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cherry Hill, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>R. T. Jones</b>				ADDRESS <b>Newark, Del.</b>		24a. REC'D BY REGISTRAR <b>521 4 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>Adams</b>			

CERTIFICATE OF DEATH

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BUREAU V. S.

FEB 14 1933

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1889

Reg. Dist. No.

01897

1. PLACE OF DEATH a. COUNTY Cecil Ct. MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Md. b. COUNTY Cecil			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Elkton, R. D. 4				c. LENGTH OF STAY IN 1b 60 years			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Union Hospital, D.O. A.				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Elizabeth W. Middle Szilvay Last				4. DATE OF DEATH Month 2/18/58 Day 19 Year			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3/10/1894	
9. AGE (In years last birthday) 63 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				10b. KIND OF BUSINESS OR INDUSTRY Housekeeping		11. BIRTHPLACE (State or foreign country) Hungary	
12. CITIZEN OF WHAT COUNTRY? U.S.A.							
13. FATHER'S NAME Mathew Waltrith				14. MOTHER'S MAIDEN NAME Kirschenheuter			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. None		17. INFORMANT John Szilvay R. D. 4 Elkton, Md.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Accute coronary 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE R.C. Dodson				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
EXAMINER'S NAME (Type) R.C. Dodson				DATE SIGNED 2/19/58			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 2/24/58		22c. NAME OF CEMETERY OR CREMATORY Greenmount Cemetery		22d. LOCATION (City, town, or county) (State) Philadelphia, Penna.	
23. FUNERAL DIRECTOR'S SIGNATURE Pepper's Funeral Home				ADDRESS 1001 N. Dec. City, Md.		24a. REC'D BY REGISTRAR DATE	
				24b. REGISTRAR'S SIGNATURE			

FEB 26 '58

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age		Date of Birth	
John William		Male		60 Years		Dec 1 1893	
Place of Birth		Cause of Death		Manner of Death		Occupation	
Maryland		Heart Disease		Natural		Farmer	
Residence		Date of Death		Time of Death		Place of Death	
Baltimore		Feb 26 1953		10:00 AM		Home	
Physician		Medical Examiner		Coroner		Jury	
Dr. J. H. Smith		J. H. Smith		J. H. Smith		J. H. Smith	
Signature		Signature		Signature		Signature	
[Signature]		[Signature]		[Signature]		[Signature]	

BUREAU V. S.  
FEB 26 1953

RECEIVED



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1890

## CERTIFICATE OF DEATH

Reg. Dist. No. 01898

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Del.</b> b. COUNTY <b>N.C.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Union Hospital</b>				d. STREET ADDRESS <b>Pleasant Valley Road, Newark</b>			
3. NAME OF DECEASED (Type or print) First <b>Rudolph I</b> Middle <b>VALENTINE</b> Last <b>VALENTINE</b>				4. DATE OF DEATH Month <b>Feb.</b> Day <b>28</b> Year <b>1958</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Col.</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1902</b>		9. AGE (In years lost birthday) <b>55 yrs.</b>	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Mechanic</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Self-employed</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Gibson Valentine</b>				14. MOTHER'S MAIDEN NAME <b>Katherine Congo</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT <b>Willard Valentine-Elkton, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ACUTE INTESTINAL OBSTRUCTION</b> <b>180x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>GENERALIZED CARCINOMATOSIS</b> DUE TO (c) <b>CARCINOMA OF RIGHT KIDNEY</b>						INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>3 mo.</b> <b>6 mo.?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>2-12</b> , 19 <b>58</b> , to <b>2-25</b> , 19 <b>58</b> , that I last saw the deceased alive on <b>2-25</b> , 19 <b>58</b> , and that death occurred at <b>1:40 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>154 W. MAIN</b> DATE SIGNED <b>2-25-58</b>							
ACTUAL SIGNATURE <b>Peter Stavakis</b>				M.D. <b>ELKTON Md.</b>			
PHYSICIAN'S NAME (Type) <b>PETER STAVAKIS</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>3/1/58</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Thomas Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Glasgow, Del.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ernest K Bell</b>				ADDRESS <b>Wilmington, Del.</b>		24a. REC'D BY REGISTRAR DATE <b>FEB 27 '58</b>	
				24b. REGISTRAR'S SIGNATURE <b>W. H. Beach</b>			

TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. DATE OF DEATH		8. PLACE OF DEATH		9. CAUSE OF DEATH		10. MANNER OF DEATH		11. SIGNATURE OF REGISTRAR		12. SIGNATURE OF DECEASED	

## 01899

1. PLACE OF DEATH a. COUNTY <b>Cecil</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Del</b>		b. COUNTY <b>NewCastle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Elkton</b>		c. LENGTH OF STAY IN 1b <b>D.O.A.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wilmington</b>		46X 3	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Union Hospital</b>				d. STREET ADDRESS <b>312 N. Harrison</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Harry</b>		First <b>N</b>		Middle <b>Wheeler</b>		Last <b>19 58</b>	
5. SEX <b>M</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>12-11-1925</b>	
9. AGE (In years last birthday) <b>32</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto worker</b>		11. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Hardy K. Wheeler</b>		14. MOTHER'S MAIDEN NAME <b>Pearl Chambers</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>237-40-4007</b>	
17. INFORMANT <b>Harry K. Wheeler</b>		Address <b>Asheville, N.C.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Laceration left side of face fractured Jaw and skull</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>and laceration of forehead and crushed chest.</b> DUE TO (c) <b></b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b></b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Car ran under a Tractor Tractor</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour <b>7.25</b> p. m.		Month, Day, Year <b>1 7 58</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Route 40</b>	
20f. (City or town) <b>Elkton</b>		(County) <b>Cecil</b>		(State) <b>Md.</b>		21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
ACTUAL SIGNATURE <b>R.C. Dodson</b>		M.D. <b>R.C. Dodson</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>2-8-58</b>	
EXAMINER'S NAME (Type) <b>R.C. Dodson</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal</b>		22b. DATE THEREOF <b>Feb. 9, 1958</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Barnsville, N.C.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pippin Funeral Home</b>		ADDRESS <b>Donald M. Gee Elkton, Md</b>		24a. REC'D BY REGISTRAR <b>DATE</b>		24b. REGISTRAR'S SIGNATURE	

**TO DEPUTY CHIEF MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Age		Sex		Race		Date of Death		Place of Death	
John Doe		45		Male		White		Jan 15, 1938		New York City	
Cause of Death		Manner of Death		Occupation		Education		Marital Status		Previous Illnesses	
Heart Disease		Natural		Carpenter		High School		Married		None	
Signature of Medical Examiner		Signature of Coroner		Signature of Registrar		Signature of Witness		Signature of Deceased		Signature of Family	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

**RECEIVED**  
FEB 13 1938  
**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No. 96

01900

1958

1. PLACE OF DEATH a. COUNTY <b>Cecil</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Perry Point</b>		c. LENGTH OF STAY IN 1b <b>2 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <b>Veterans Administration Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>L.</b> Last <b>WHITMORE</b>		4. DATE OF DEATH Month <b>February</b> Day <b>24</b> Year <b>19 58</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>8-5-97</b>
9. AGE (In years last birthday) <b>60</b> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Liquor Store</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles T. Whitmore</b>		14. MOTHER'S MAIDEN NAME <b>Annie Timmons</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> <b>WW II</b>		16. SOCIAL SECURITY NO. <b>unknown</b>	
17. INFORMANT <b>Hospital Records, VAH, Perry Point, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, bilateral, unresolved</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic heart disease</b> DUE TO (c) <b>Emphysema bilateral severe</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis generalized severe - unknown</b>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>VA</b> <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>February 22, 1958</b> to <b>February 24, 1958</b> and that death occurred at <b>9:30 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>S. P. LACERVA</b>		DATE SIGNED <b>2-25-58</b>	
PHYSICIAN'S NAME (Type) <b>S. P. LACERVA</b>		Director, Professional Services	
22a. BURIAL CREMATION, REMOVAL (Specify) <b>2/28/58</b>		22b. DATE THEREOF	
22c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		22d. LOCATION (City, town, or county) (State) <b>Baltimore, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Pennington &amp; Son</b>		ADDRESS <b>Harve de Grace, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>MAR 4 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Al. Smith</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



INVESTIGATION OF DEATH

BUREAU V. S.

MAR 4 1958

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

1958

CERTIFICATE OF DEATH

Reg. Dist. No. 01901

1. PLACE OF DEATH a. COUNTY <u>Cecil</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Cecil</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>				c. LENGTH OF STAY IN 1b years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cecilton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Water Street</u>				d. STREET ADDRESS <u>Water Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>Ida Showell Wilson</u>				4. DATE OF DEATH Month Day Year <u>Feb 4 19 58</u>			
5. SEX <u>female</u>		6. COLOR OR RACE <u>Negro</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec. 6, 1874</u>	
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Chester, Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Alexander Showell</u>				14. MOTHER'S MAIDEN NAME <u>Clara-?</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT Address <u>Alexander Wilson-Cecilton, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> 332 x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral arteriosclerosis</u> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> yers							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>Dec 11</u> , 19 <u>57</u> , to <u>Feb 4</u> , 19 <u>58</u> that I last saw the deceased alive on <u>Feb 4</u> , 19 <u>58</u> , and that death occurred at <u>8:00 pm</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Wallace Obenshain</u> M.D.				DATE SIGNED <u>Cecilton, Md 6 Feb 58</u>			
PHYSICIAN'S NAME (Type) <u>Wallace Obenshain, M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>2/8/58</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cecilton Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cecilton Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Edw. K. Beel</u> ADDRESS <u>909 Poplar St.</u>				24a. REC'D BY REGISTRAR DATE <u>FEB 10 '58</u>		24b. REGISTRAR'S SIGNATURE <u>W. S. Beach</u>	

# CERTIFICATE OF DEATH

Water Street

Ida

Showell

Willsa

Female Negro

X

Dec. 1

Housewife

Own Home

Cher

Alexander Showell

Cl

none

Alexander

Cerebral thrombosis

Cerebral arteriosclerosis

BUREAU V. S.

Feb 1 8:00pm

FEB 10 1938

Cec

Cec

RECEIVED